HORIZON PSYCHIATRY

Child & Adolescent Psychiatric Medication Management Intake Packet

Today's date: _____
Name: _____
Date of Birth: _____
Allergies: _____

List all current medications including over the counter medications and supplements:

Medication	Dose	How are you taking

Please list any symptoms you have currently been struggling with:

_____
_____
_____

Psychiatric History:

Do you have a primary care provider: Yes / No
If yes, who and where? _____

Have you seen a healthcare provider for medication management of mental illness? Yes / No
If yes, whom? _____

Are you currently seeing a therapist? Yes / No
If yes, who and where? _____

Have you ever participated in any of the listed treatments?

	Yes	No	Comments
Individual Therapy			
Group Therapy			
Family Therapy			
Day Treatment			
DBT			
EMDR			
ECT			
Parenting Therapy			
Play Therapy			

Have you ever been hospitalized for a mental illness? Yes / No If yes, please complete chart below:

Hospital Name	Approximate dates	Brief description of symptoms during that hospitalization.
1.		
2.		
3.		
4.		
5.		

Do you have any guns in the home? Yes / No

If yes, are they locked away? Yes / No

Have you ever attempted suicide? Yes / No

If yes, please explain. (Include approximate date and by what method).

_____

_____

Have you ever engaged in self-injurious behavior? Yes / No

If yes, please explain. (Include approximate date and by what method).

_____

_____

Medical History:

Please list any medical diagnoses that you have: (i.e.: hypertension, diabetes, high cholesterol, eating disorder, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any surgical procedures that you have had:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had a seizure or been diagnosed with a seizure disorder? Yes / No

Have you ever suffered from a head injury? (i.e.: loss of consciousness, brain injury, concussion.) Yes / No

Substance Use:

Have you ever **used** or **abused** any alcohol or drugs? Yes / No

If yes, please complete chart below:

Substance	Past use	Date of last use	General use per day/week/month
Alcohol			
Tobacco/Vape/Nicotine			
Caffeine			
Marijuana/CBD			
Methamphetamine			
Narcotics			
Cocaine			
Heroin			
Hallucinogens			
Prescription Medication			
Other:			

If you use any drugs or alcohol, please complete table below (**Ages 12 and up only**):

CAGE-AID	Yes	No
Have you ever felt you ought to cut down on your drinking or drug use?		
Have people annoyed you by criticizing your drinking or drug use?		
Have you felt bad or guilty about your drinking or drug use?		
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?		

Have you ever been in a chemical dependency treatment program? Yes / No
If yes, please complete the chart below:

Program	Approximate dates	Drug of treatment

Legal History:

Have you ever been charged with a crime? Yes / No
If yes, please explain: _____

Have you ever spent time in a juvenile detention program? Yes / No
If yes, please explain: _____

Are you currently on probation? Yes / No

Social History:

Where were you born? _____

Where were you raised? _____

If not born in the U.S., when did you move to the U.S.?
_____

Were you adopted? Yes / No
If so, at what age? _____

Current place of residence? (i.e.: House/apartment/Foster Home/Group Home)
_____

Who currently lives in your home? _____
How was the mother's overall health during the pregnancy with this patient?
(Good/fair/poor/don't know): _____

What substances, if any, did the mother use during the course of the pregnancy?
(Alcohol/tobacco/street drugs):_____

Premature delivery? Yes / No (Weeks gestation): _____

Delivery method? (Vaginal/breech/caesarian/forceps/vacuum assisted/induced): _____

Birth Weight? _____

Do you feel safe in your home? Yes / No

Is anyone in your home hurting you? Yes / No

Do you have any children? Yes / No
If yes, list names and ages _____
_____

Were your parents married? Yes / No

Did your parents remain married? Yes / No

Do you have brothers and/or sisters? Yes / No
If yes, state names and ages_____
_____

Are you the oldest, middle, or youngest of your siblings? _____

Check all completed education:

Education	Current Grade
Elementary School	
Middle School	
High School	
College Courses	

Current school: _____
Special Education/IEP/504: _____
Social Worker: _____

Currently employed? Yes / No
If yes, where, # hours? _____

Disabled? Yes / No

What is your religious affiliation? _____

Do you currently practice? Yes / No

How important is your faith to you? Very / somewhat / not at all

Do you have any history of abuse? Yes / No
If yes, please complete this table:

	By whom	Dates
Verbal		
Emotional		
Physical		
Sexual		

Family History:

Do any of your relatives have mental illness or chemical dependency issues? Yes / No
If yes, please complete:

Condition	Relationship: i.e.: mother, father, brother, sister, maternal side or paternal side.
Anxiety	
Depression	
ADHD	
Bipolar disorder	
Schizophrenia	
Psychosis	
Alcoholism	
Drug use	
Dementia/Alzheimer's	
Suicide attempted	
Suicide completed	
OCD	
Personality Disorders	
PTSD	

Past Medication History:

Please identify any medications that you have taken in the past. Please also indicate any response to each medication that you can remember.

Medication	Approximate dates	Side Effects/response
Anti-depressants:		
Amitriptyline (Elavil)		
Atomoxetine (Strattera)		
Buproprion (Wellbutrin)		
Citalopram (Celexa)		
Clomipramine (Anafranil)		
Desipramine (Norpramin)		
Desvenlafaxine (Pristiq)		
Dothiepin		
Doxepin (Sinequan)		
Doxepin (Silenor)		
Duloxetine (Cymbalta)		
Escitalopram (Lexapro)		
Fluoxetine (Prozac)		
Fluvoxamine (Luvox)		
Imipramine (Tofranil)		
Isocarboxazid (Marplan)		
Levomilnacipran (Fetzima)		
L-Methylfolate (Deplin)		
Lofepramine (Deprimyl)		
Lofepramine (Gamanil)		
Maprotiline (Ludiomil)		
Mianserin (Lerivon)		
Milnacipran (Toledomin/Ixel/Savella)		
Mirtazapine (Remeron)		
Moclobemide (Aurorix/Arima/Manerix)		
Nefazodone (Dutonin) (Serzone)		
Nortriptyline (Pamelor)		
Paroxetine (Paxil)		
Phenelzine (Nardil/Nardelzine)		
Protriptyline (Triptil/Vivactil)		
Reboxetine (Norebox/Edronax)		
Selegiline (EMSAM/Eldepryl)		
Sertraline (Zoloft)		

Tianeptine (Coaxil/Stablon/Tatinol)		
Tranylcypromine (Parnate)		
Triiodothyronine (Cytomel)		
Trimipramine (Surmontil)		
Venlafaxine (Effexor)		
Vilazodone (Viibryd)		
Vortioxetine (Trintellix)		
Other:		

Medication	Approximate dates	Side effects/response
Anti-Anxiety Medications:		
Alprazolam (Xanax)		
Buspirone (Buspar)		
Clonazepam (Klonopin)		
Clonidine (Catapres)		
Diazepam (Valium)		
Gabapentin (Neurontin)		
Hydroxyzine (Vistaril)		
Lorazepam (Ativan)		
Propranolol (Inderal)		
Other:		

Medication	Approximate dates	Side effects/response
Mood Stabilizing Medications:		
Carbamezapine (Tegretol)		
Gabapentin (Neurontin)		
Lamotrigine (Lamictal)		
Levetiracetam (Keppra)		
Lithium (Lithobid/Eskalith)		
Oxcarbazepine (Trileptal)		
Topiramate (Topamax)		
Valproate (Depakote)		
Other:		

Medication	Approximate dates	Side effects/response
Antipsychotic Medications:		
Aripiprazole (Abilify)		
Asenapine (Saphris)		
Brexpiprazole (Rexalti)		
Cariprazine (Vraylar)		
Chlorpromazine (Thorazine)		

Clozapine (Clozaril)		
Cyamemazine (Tercian)		
Flupenthixol (Depixol)		
Fluphenazine (Prolixin)		
Haloperidol (Haldol)		
Iloperidone (Fanapt)		
Lofepramine (Deprimyl/Gamanil)		
Loxapine (Loxitane/Adasuve)		
Lurasidone (Latuda)		
Mesoridazine (Serentil/Ladanil)		
Molindone (Moban)		
Olanzapine (Zyprexa)		
Paliperidone (Invega)		
Perospirone (Lullan)		
Perphenazine (Trilafon)		
Pimozide (Orap)		
Pipothiazine (Piportil)		
Quetiapine (Seroquel)		
Risperidone (Risperdal)		
Sertindole (SERDOLECT)		
Sulpiride (Dolmatil)		
Thioridazine (Mellaril)		
Thiothixene (Navane)		
Trifluoperazine (Stelazine)		
Ziprasidone (Geodon)		
Zotepine (Lodopin/Zoleptil)		
Zuclopenthixol (Clopixol)		
Other:		

Medication	Approximate dates	Side effects/response
ADHD Medications:		
Amphetamine (Adderall)		
Amphetamine ER (Adderall ER)		
Atomoxetine (Strattera)		
Bupropion (Wellbutrin)		
Clonidine (Catapres)		
Dextroamphetamine (Dexedrine)		
Dexmethylphenidate (Focalin)		
Dexmethylphenidate ER (Focalin XR)		
Guanfacine (Intuniv)		
Lisdexamfetamine (Vyvanse)		
Methylphenidate (Ritalin)		
Methylphenidate ER (Ritalin SR)		

Methylphenidate LA (Ritalin LA)		
Methylphenidate (Metadate)		
Methylphenidate ER (Concerta)		
Other:		

Medication	Approximate dates	Side effects/response
Sleep/Wake Medications:		
Armodafinil (Nuvigil)		
Belsomra		
Doxepin (Silenor)		
Doxepin (Sinequan)		
Estazolam (ProSom)		
Eszopiclone (Lunesta)		
Modafinil (Provigil)		
Ramelteon (Rozerem)		
Temazepam (Restoril)		
Trazodone (Desyrel)		
Triazolam (Halcion)		
Zaleplon (Sonata)		
Zolpidem (Ambien)		
Zolpidem ER (Ambien CR)		
Other:		

Medication	Approximate dates	Side effects/response
Drug/Alcohol Abstinence Medications:		
Acamprosate (Campral)		
Buprenorphine (Suboxone)		
Disulfiram (Antabuse)		
Methadone		
Naltrexone (Revia/Vivitrol)		
Varenicline (Chantix)		
Other:		

Medication	Approximate dates	Side effects/response
Medications used for side effects:		
Benztropine (Cogentin)		
Diphenhydramine (Benadryl)		
Propranolol (Inderal)		
Trihexyphenidyl (Artane)		
Other:		

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

HORIZON PSYCHIATRY

CONTROLLED SUBSTANCE AGREEMENT

I understand Horizon Psychiatry, LLC is providing psychiatric treatment for Mental Health conditions which may include controlled substance medication. This treatment agreement will give us the opportunity to work together and establish a treatment plan. I understand if a treatment recommendation is not followed, termination of care may occur. I also understand that if treatment is continued, controlled substances will likely be discontinued.

1. I agree to attend regularly scheduled appointments for continuation of medication management and all other services provided by Horizon Psychiatry, LLC.

2. I understand the providers at Horizon Psychiatry, LLC follow the FDA recommended medication dosage guidelines.

3. Laboratory testing may be requested by your provider before initiating treatment and throughout the course of treatment. Horizon Psychiatry, LLC does not offer laboratory services. Orders will be given and it is the patients responsibility to bring orders to their laboratory of choice to be completed. Laboratory testing fees are patient's responsibility.

4. Non-compliance of controlled substance medications will result in discontinuation of such treatment. This would include the selling, sharing, trading, losing, or taking more than prescribed by the provider at Horizon Psychiatry, LLC.

5. I agree to keep my medications in a secure location and understand that these medications are my responsibility.

6. If I obtain a controlled substance medication prescribed by another healthcare provider, I will disclose this to my provider at Horizon Psychiatry, LLC in a timely manner.

7. I agree to disclose my pharmacy of choice and understand the importance of filling all medications at one pharmacy. I understand it is my responsibility to inform Horizon Psychiatry, LLC if my pharmacy changes at any time.

8. I understand the use of illicit drugs or alcohol is very dangerous when combined with prescription medications. I agree to abstain from the use of illicit drugs and alcohol while taking prescription medication. I agree to complete drug screenings, within 48 hours, at the request of my provider.

9. Horizon Psychiatry, LLC does not prescribe narcotic pain medications or medical cannabis.

10. I understand that benzodiazepines and stimulants will not be prescribed concurrently per the discretion of my Horizon Psychiatry, LLC provider.

11. I understand that treatment with a stimulant medication will require determination of ADHD diagnosis with psychological testing.

12. I understand the use of controlled substances may cause addiction and should be closely monitored.

13. I have been informed that taking controlled medications and operating a motorized vehicle may result in a violation of driving under the influence (DUI).

14. Refill requests for medication may take up to 5 business days. Controlled substances will not be filled earlier than 3 days before they are due. Please make refill request 5 business days prior to ensure a timely refill.

15. Lost, stolen, or otherwise missing controlled substance prescriptions will not be replaced.

By signing below, I agree that I have read and understand all information provided on this form.

Patient signature (or legal guardian) _____ Date _____

Provider signature _____ Date _____

HORIZON
PSYCHIATRY

TREATMENT AGREEMENT

I understand Horizon Psychiatry, LLC is providing psychiatric treatment for Mental Health conditions which may include the initiation or continuation of psychotropic medications. This treatment agreement will give us the opportunity to work together and establish a treatment plan to help improve overall quality of life.

1. I am consenting to treatment services and will work with my provider to establish a treatment plan that may include psychotropic medication management and referrals to therapeutic services.

2. Claims will be submitted to all insurances, disclosed by patient prior to time of service, for payment. Any remaining balances after claims have been processed by insurance companies will become patient responsibility, if applicable.

3. Additional charges may include brief psychotherapy and interactive complexity along with medication management codes dependent on provider's discretion based on acuity of visit. Itemized charges will appear on your billing statement.

4. Laboratory testing may be requested by your provider before initiating treatment and throughout the course of treatment. Horizon Psychiatry, LLC does not offer laboratory services. Orders will be given and it is the patients responsibility to bring orders to their laboratory of choice to be completed. Laboratory testing fees are patient's responsibility.

5. Refill requests for medication may take up to 5 business days. Controlled substances will not be filled earlier than 3 days before they are due. Please make refill request 5 business days prior to ensure a timely refill.

6. I agree to attend regularly scheduled appointments for ongoing assessment necessary for continuation of medication, as well as all other services provided by Horizon Psychiatry, LLC.

7. Horizon Psychiatry, LLC requires a 24-hour cancellation notice for all scheduled appointment. Appointments cancelled without a 24-hour notice, missed appointments, or showing up late (will result in late cancellation) will be assessed a $120.00 fee. This fee will be the responsibility of the patient and will not be submitted to insurance for payment.

8. I understand that if I arrive late for my scheduled appointment this appointment will be cancelled. A new appointment may be scheduled not earlier than the following business day.

9. I understand if I cancel (without 24-hour notice) or miss scheduled appointment 3 times in a 12 month period my care will be terminated at Horizon Psychiatry, LLC.

10. Horizon Psychiatry, LLC does not offer after hours' service. Hours of clinic operation are Monday through Thursday from 7am to 5pm. If immediate assistance is needed, please call 911 or report to the nearest emergency services facility.

11. Dishonest or disrespectful behavior will not be tolerated at Horizon Psychiatry, LLC and will result in immediate termination. (i.e. disrespectful, profane, or aggressive language, aggressive behavior or threats).

By signing below, I agree that I have read and understand all information provided on this form.

Patient signature (or legal guardian) _____ Date _____

Provider signature _____ Date _____

HORIZON
PSYCHIATRY

Acknowledgement of Receipt of Privacy Practice Notification
Client Information and Office Policy Statement
Authorization for Treatment & Payment

Name of Client: _____ Date of Birth: _____

By signing this document, you are acknowledging the following:

1. I have been offered and/or received a copy of Horizon Psychiatry Client Information and Office Policy Statement as well as the Notice of Privacy Practices. I understand my rights, including those related to confidentiality and its limitations.
2. I understand the service that will be provided and I consent to treatment for myself. Psychiatric/Mental health services may include diagnostic interview, brief psychotherapy, specialized assessments (if indicated) and involvement in the treatment planning process for all services that are received through this clinic.
3. I authorize Horizon Psychiatry to release/exchange information with my insurance company. I hereby authorize payment directly to Horizon Psychiatry of the policy benefits otherwise payable to me, but not to exceed the provider's regular charges for the period of treatment. I understand that I am financially responsible to Horizon Psychiatry for all charges not covered by my current benefits and all co-pays are due at time of service.

Please note, you are responsible for knowing your benefits and coverage. You are responsible for notifying Horizon Psychiatry of any insurance change or loss of coverage. Should you secure services without coverage, it is your responsibility to pay Horizon Psychiatry for services received. If payment for client responsibility is not rendered, services may be suspended until payment is received.

4. Do you wish for Horizon Psychiatry to notify your primary care provider that you are receiving services, for purposes of coordinating care? NO YES If YES, please complete a separate Release of Information form and specify what information you would like to be shared.

Client's (or Legal Representative's) Signature: _____ Date: _____

Legal Representative of client please print name: _____

HORIZON
PSYCHIATRY

Client Information & Office Policies

- Horizon Psychiatry, LLC hours of operation are Monday through Thursday from 7am to 5pm. If you call outside of normal business hours please feel free to leave a message, your request will be addressed within forty-eight (48) business hours.

- If, at any time outside of regular business hours, you require emergency or immediate care please report to the nearest ER or call 911.

- Patient must present to initial assessment sixty (60) minutes prior to scheduled appointment start time for adequate time to complete necessary forms and intake process.

- Insurance information and patient demographics must be provided to Horizon Psychiatry, LLC at least twenty-four (24) business hours prior to scheduled appointment time. If information is not furnished within this timeframe, patient appointment may be cancelled.

- It is your responsibility, as a patient, to notify Horizon Psychiatry, LLC of any lapse of insurance coverage.

- If, at any time, there is a lapse in your insurance coverage, you will be responsible for any services rendered as "private pay" (amount listed below).

- Patient must pay copay at time of visit.

- Balance owed by patient must be paid in full no later than next scheduled visit. If patient is unable to pay balance in full, they may request to initiate a scheduled repayment plan.

- If no attempt of payment is made, all future appointments will be cancelled.

- If balance owed by patient is greater than $1,000.00 patient account will be frozen and no appointments will be scheduled until account is in good standing.

- If balance owed by patient is delinquent greater than 90 calendar days, patient account may be subject to collection agency.

- Patient account will be charged a minimum fee of $25.00 for payments returned due to insufficient funds.

- Any private pay initial assessment appointment will be charged $215.00 and follow-up appointment will be charged $215.00 per occurrence. Horizon Psychiatry, LLC will make every possible attempt to notify patient of private pay status as early as possible.

- Payment in full will be expected at the time of or prior to scheduled appointment for all private pay services.

HORIZON PSYCHIATRY

Late Cancel/No Show Policy

- Patient must call twenty-four (24) business hours in advance to cancel or reschedule any appointment. In the event patient does not call before this timeframe a late cancel status will be applied to their scheduled appointment.

- If patient fails to present for appointment or call after appointment start time, a no show status will be applied to their scheduled appointment. At this time, patient will be mailed a notification letter regarding policy and status of their compliance with this policy.

- If patient fails to present for their initial assessment, they will be terminated from care. They may write a letter of appeal for the possibility of being granted a second chance for an initial assessment with a medication provider dependent upon board review. If same patient misses initial intake with medication provider after second chance is granted, they will be permanently terminated from medication services at Horizon Psychiatry, LLC.

- If patient presents late for scheduled appointment, a late cancel status will be applied to their scheduled appointment. A new appointment may be scheduled no earlier than the next business day.

- If patient presents late to three (3) follow-up appointments in a twelve (12) month period, they will be permanently terminated from medication management services at Horizon Psychiatry, LLC.

- A no show/late cancel can be waived at provider's discretion.

- A no show/late cancel fee of $120.00 will be assessed for any missed appointment without reasonable cause.

Horizon Psychiatry, LLC

21370 John Milless Drive, Suite #210
Rogers MN 55374
www.horizonpsychiatry.org
(763) 428-2288

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

* *We do not create or manage a hospital directory.*

* *We do not create or maintain psychotherapy notes at this practice.*

* *We will never share any substance abuse treatment records without your written permission.*

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date of notice: May 1st, 2017

This Notice of Privacy Practices applies to the following organizations.

Horizon Psychiatry, LLC
21370 John Milless Drive, Suite #210
Rogers, MN 55374

If you have any questions or concerns please contact: Jackie Zinken, RHIA, CCS-P, Director of Operations, at (763) 428-2288.

How Can I Quit Smoking?

Smoking harms almost every tissue and organ in the body, including your heart and blood vessels. It also harms nonsmokers who are exposed to secondhand smoke.

If you smoke, you have good reason to worry about its effect on your health and the health of your loved ones and others. Deciding to quit is a big step. Following through is just as important. Quitting tobacco and nicotine addiction isn't easy, but others have done it, and you can, too.

Is it too late to quit smoking or vaping?

It's never too late to quit. In the year after you quit smoking, your excess risk of coronary heart disease drops by 50%. After 10 years, your risk is as low as that of someone who has never smoked. While you may crave tobacco or nicotine after quitting, most people feel that becoming tobacco-free is the most positive thing they've ever done for themselves.

How do I quit?

You are more likely to quit for good if you prepare for two things: your last cigarette, and the cravings, urges and feelings that come with quitting. Think about quitting in five steps:

1. **Set a Quit Date.** Choose a date within the next seven days when you will quit smoking or vaping. Tell your family members and friends who are most likely to support your efforts.
2. **Choose a method for quitting.** There are several ways to quit. Some include:
   - Stop all at once on your Quit Day.
   - Cut down the number of cigarettes per day or how many times you vape until you stop completely.
   - Smoke only part of each cigarette. If you use this method, you need to count how many puffs you take from each cigarette and reduce the number every two to three days.
3. **Decide if you need medicines or other help to quit.** Talk with your health care provider to determine which medicine is best for you. Get instructions for using it. These may include nicotine replacements (gum, lozenges, spray, patch or inhaler) or prescription medicines, such as bupropion hydrochloride or varenicline. You could also ask about a referral for a smoking cessation program.
4. **Plan for your Quit Day.** Get rid of all the cigarettes, matches, lighters, ashtrays and tobacco products in your home, office and car. Find healthy substitutes for smoking. Go for walks. Keep sugarless gum or mints with you. Munch carrots or celery sticks.
5. **Stop smoking on your Quit Day.**

What if I smoke or vape after quitting?

It's hard to stay off tobacco and nicotine once you've given in, so do everything you can to avoid that "one." The urge will pass. The first two to five minutes will be the toughest. If you do smoke or vape after quitting:

- This doesn't mean you're a smoker again—do something now to get back on track.
- Don't punish or blame yourself—tell yourself you're still a nonsmoker.
- Think about what triggered the urge and decide what to do differently the next time.

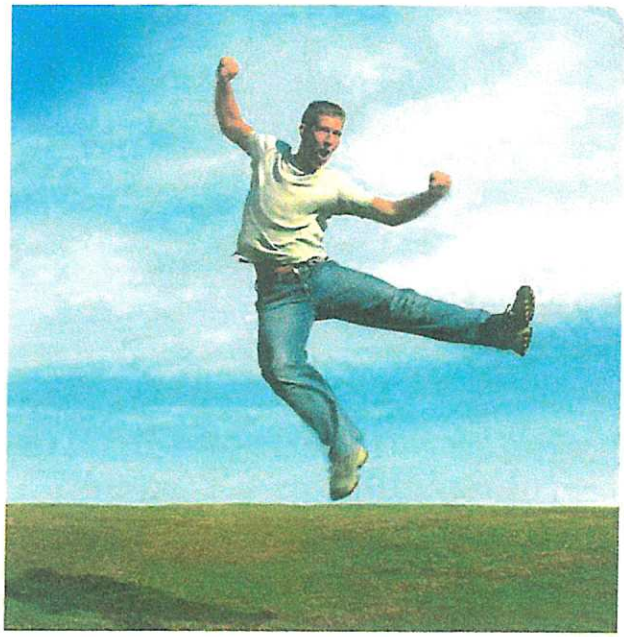
(continued)

American Heart Association.

- Sign a contract to stay tobacco-free.

What happens after I quit?

- Your senses of smell and taste come back.
- Your smoker's cough will go away.
- You'll breathe more easily.
- You'll be free from the mess and smell and the burns on your clothing.
- You'll increase your chances of living longer and reduce your risk of heart disease and stroke.



HOW CAN I LEARN MORE?

1. Call 1-800-AHA-USA1 (1-800-242-8721), or visit **heart.org** to learn more about heart disease and stroke.
2. Sign up to get ***Heart Insight***, a free magazine for heart patients and their families, at **heartinsight.org**.
3. Connect with others sharing similar journeys with heart disease and stroke by joining our Support Network at **heart.org/supportnetwork**.

Do you have questions for the doctor or nurse?

Take a few minutes to write down your questions for the next time you see your health care provider.

For example:

When will the urges stop?

How can I keep from gaining weight?

MY QUESTIONS:

We have many other fact sheets to help you make healthier choices to reduce your risk, manage disease or care for a loved one. Visit **heart.org/answersbyheart** to learn more.